2023 Oregon Rural Health Conference

The State of Rural Healthcare – Looking Forward

PERSPECTIVE

CHANGES EVERYTHING.

WIPFLI

Overview of today's discussion points

State of Rural Health Care report **01**

Strategic responses **02**

Closing comments and Q&A **03**

State of Rural Health Care report

The state of rural healthcare
Research report data for 2023

Nearly one in five Americans live in rural areas and rely on clinics and critical access hospitals for lifesaving medical services.

Wipfli surveyed more than 100 rural healthcare organizations to get a pulse on their financial health. Our inaugural state of rural healthcare report covers some of their top financial challenges and strategic responses.

Wipfli surveyed 110 rural healthcare organizations across 25 states to learn how they're coping. We learned that bad news exists — but so does hope and optimism. The majority of the rural providers we surveyed are in good financial health and confident about the future.

110

rural healthcare organizations surveyed

across **25** states

Strategic priorities for rural healthcare organizations

To maintain financial health, rural healthcare organizations are addressing four strategic priorities:

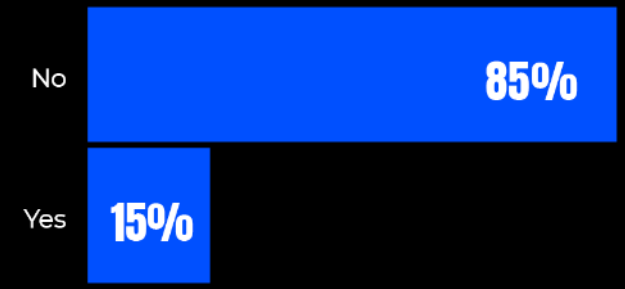
1. Talent
2. Patient experience
3. Financial performance
4. Digital transformation

Priority No. 1

Manage talent in a record-tight labor market

Has your organization experienced a workforce shortage similar to the rest of the nation?

The industry has seen an influx of hospital executives with little or no healthcare administration experience. Is this true for your organization?



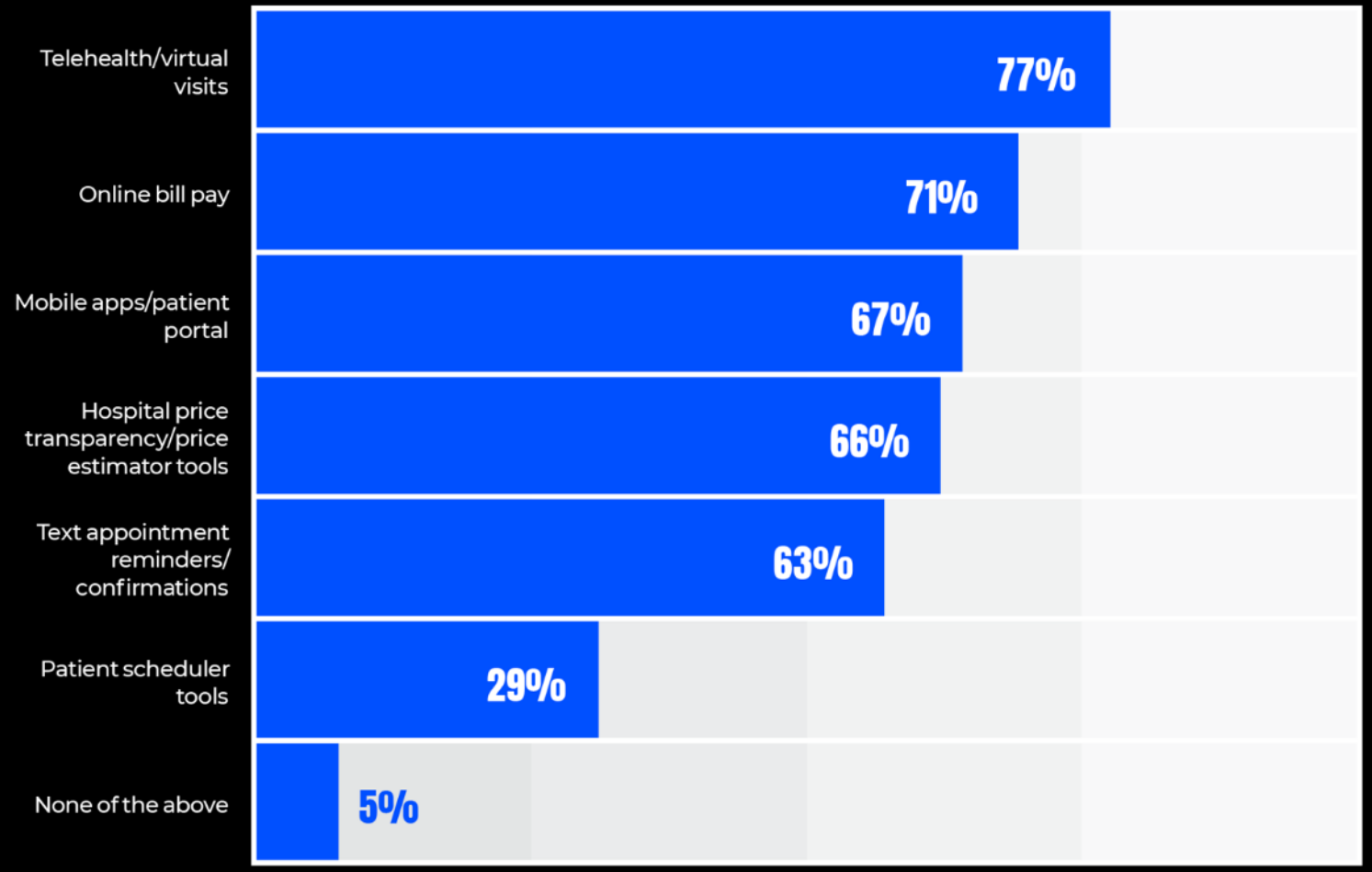
The top five ways rural healthcare organizations are addressing the labor shortage:

1. **Increasing wages**
2. **Recruiting candidates more proactively**
3. **Using technology**
   (e.g., automated phone systems and apps)
4. **Using traveling/temporary nonclinical staff**
5. **Developing medical education and residency programs**

Priority No. 2

Improve the patient experience

Which of the following tools have you developed/implemented to improve the consumer/patient experience?

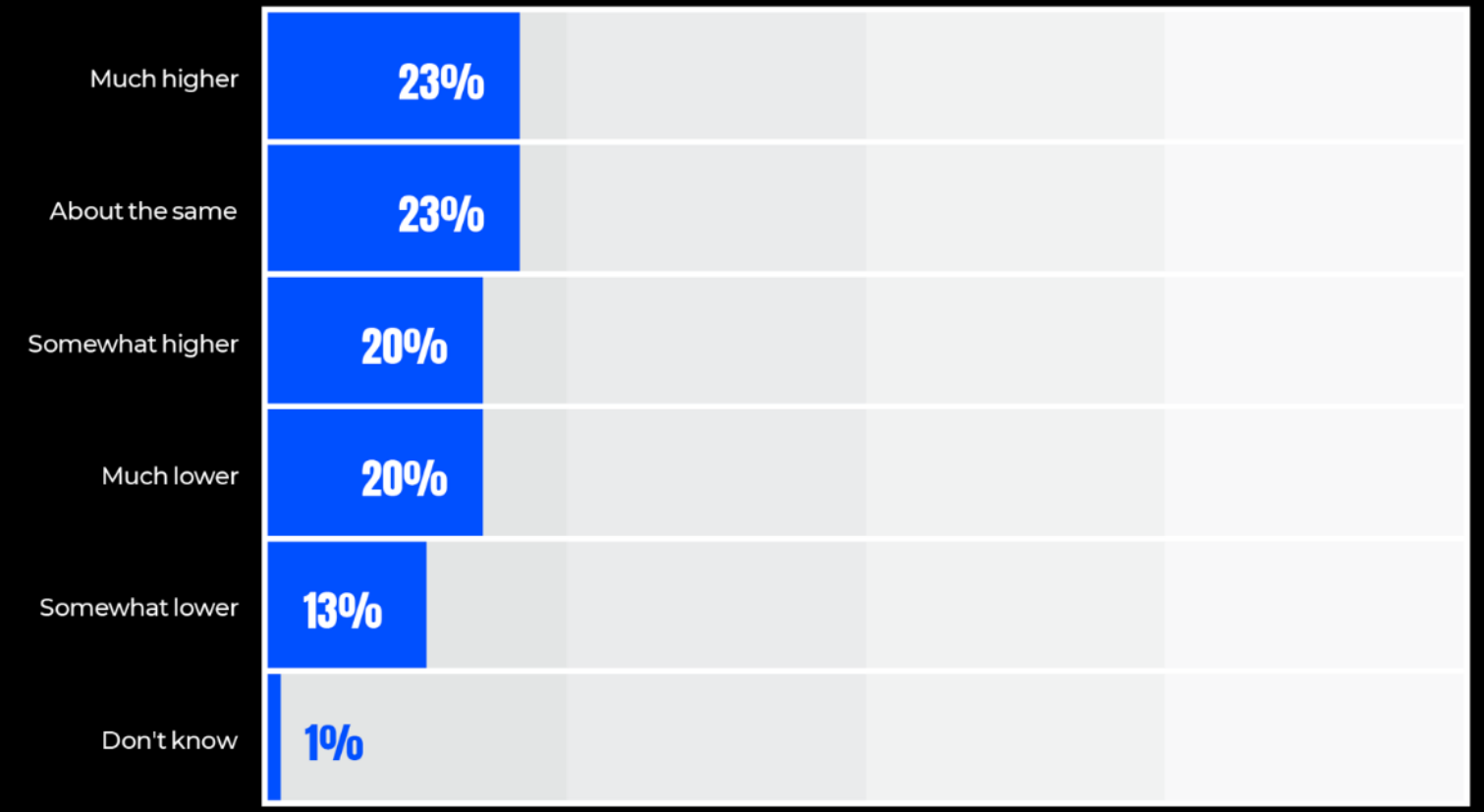


(Respondents were allowed to choose multiple responses.)

Priority No. 3

Strengthen financial performance

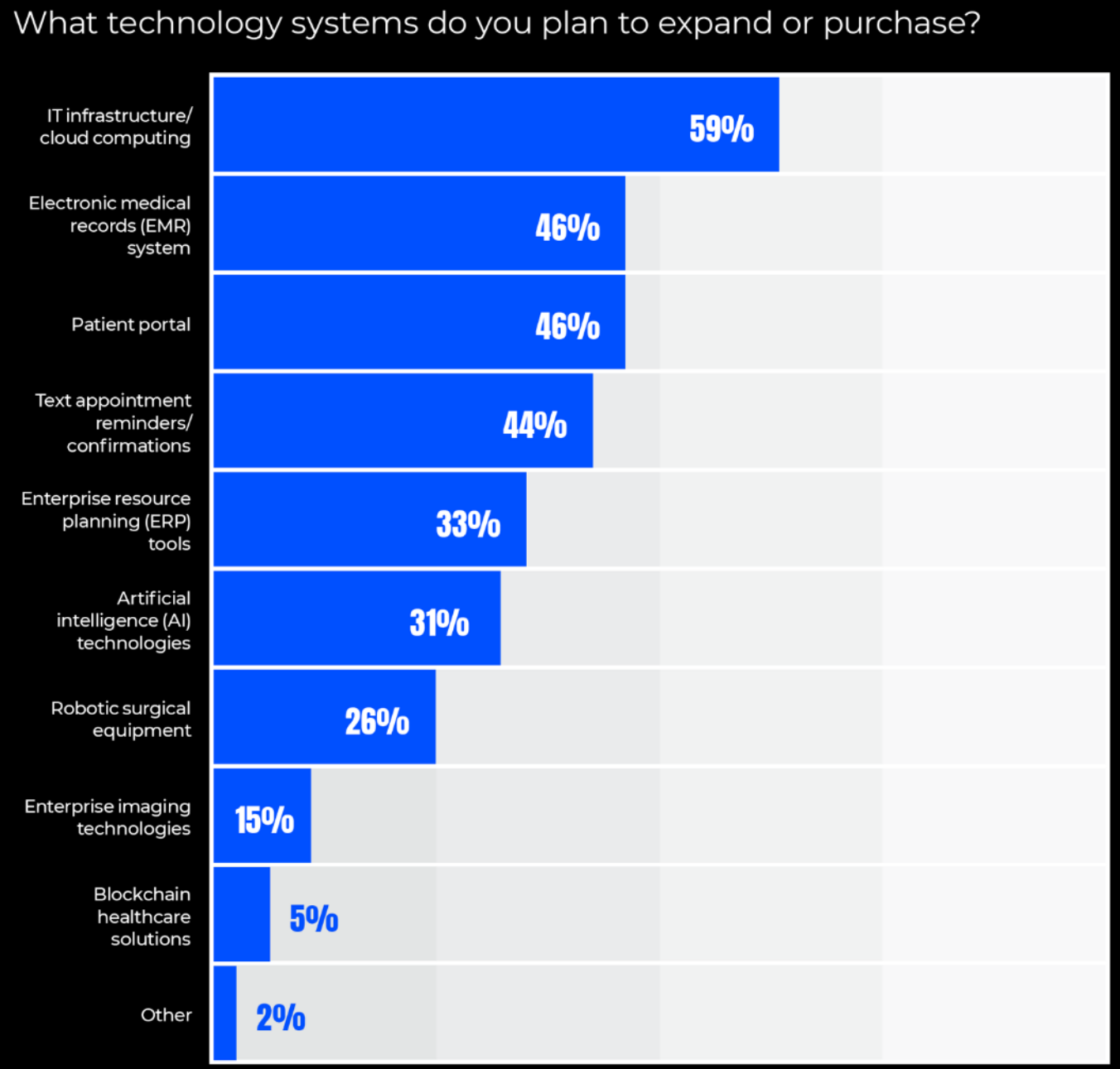
Which statement best describes your organization's level of financial stability as compared to five years ago?



(Respondents were allowed to choose multiple responses.)

Priority No. 4

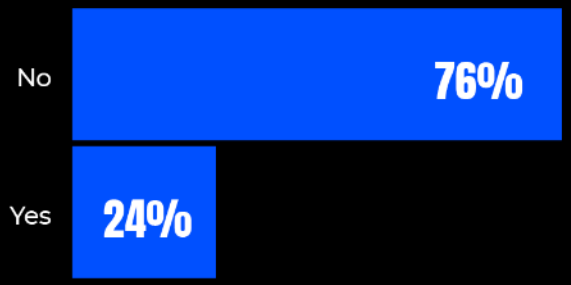
Pursue digital tools and experiences



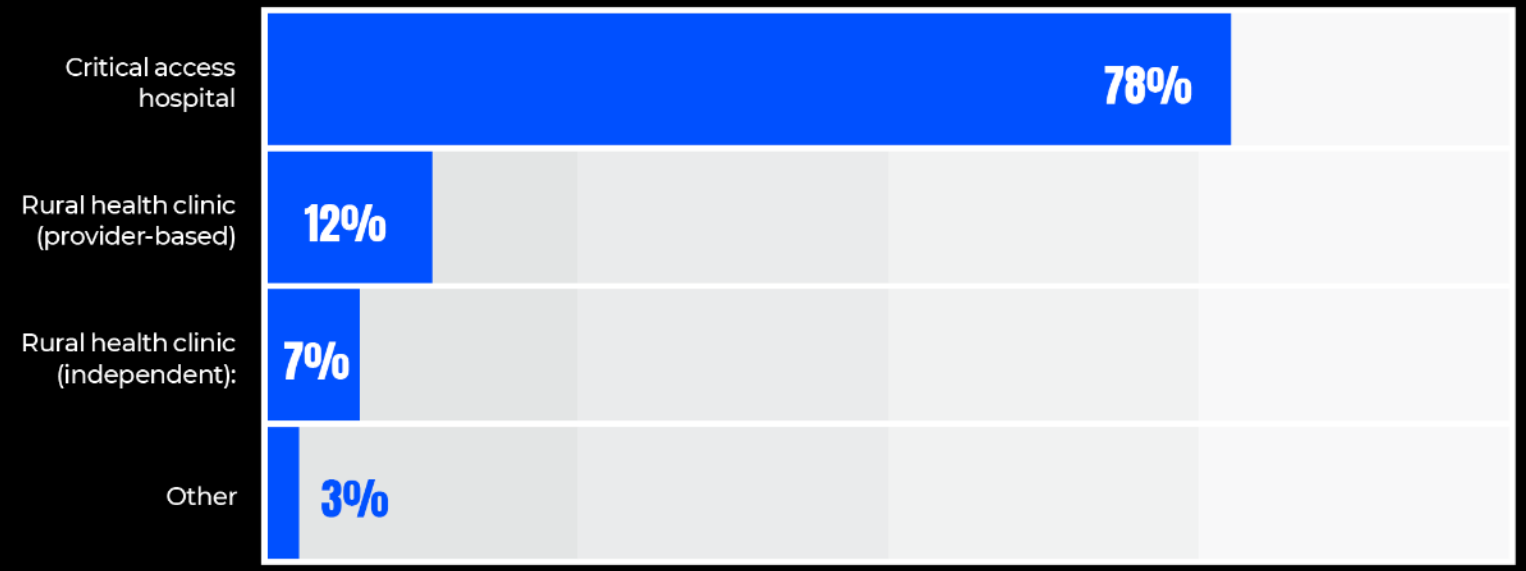
Appendix: The raw data

- Wipfli received survey responses from 110 healthcare leaders in 25 states.
- The survey was emailed out and answers were collected in mid-October through November of 2022. All responses were confidential and anonymous.
- Percentages may not equal 100% due to rounding.

Do you have an affiliation with a larger health system?

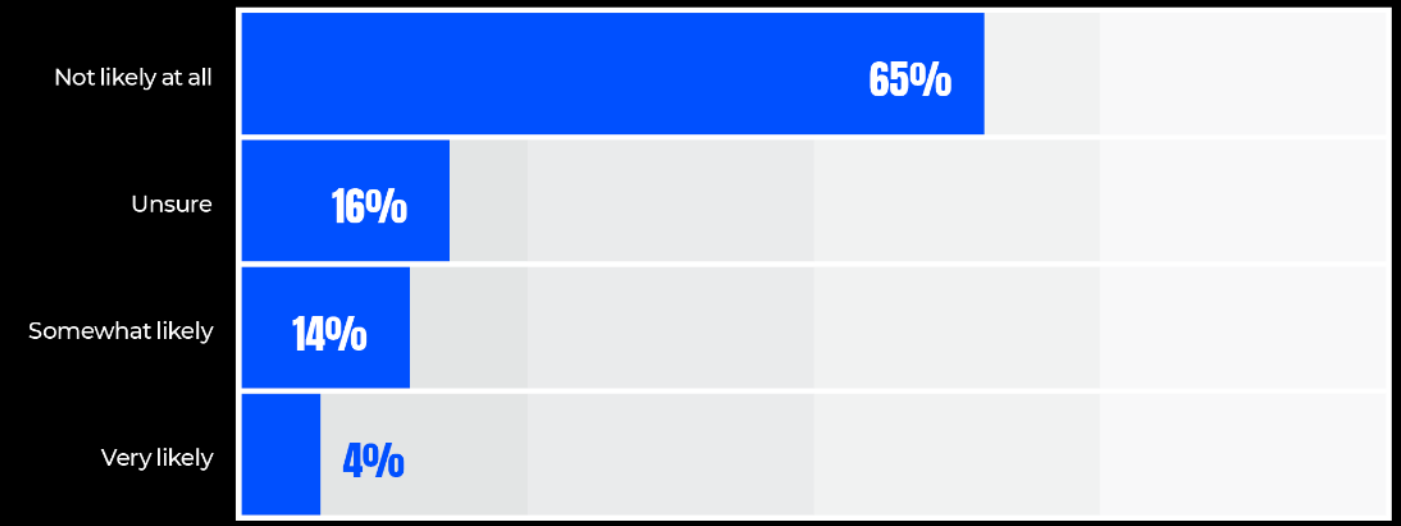


Which of the following best describes your organization?

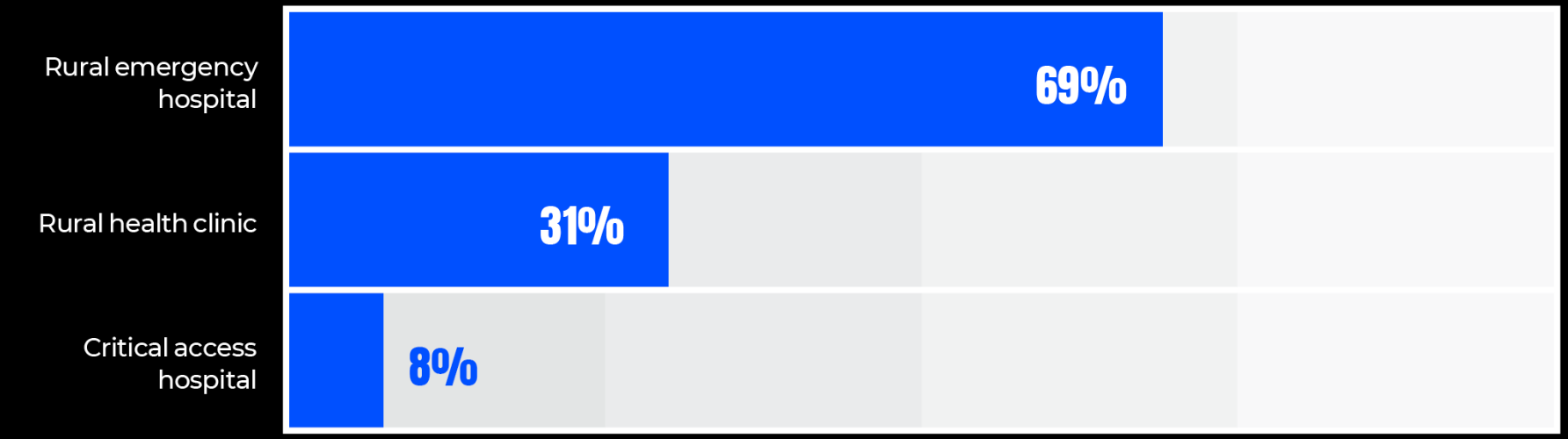


There are a number of different care designations emerging that could potentially improve your financial stability. Are you considering a different model of payment (e.g., rural emergency hospital, conversion to critical access hospital status or rural health clinic?)

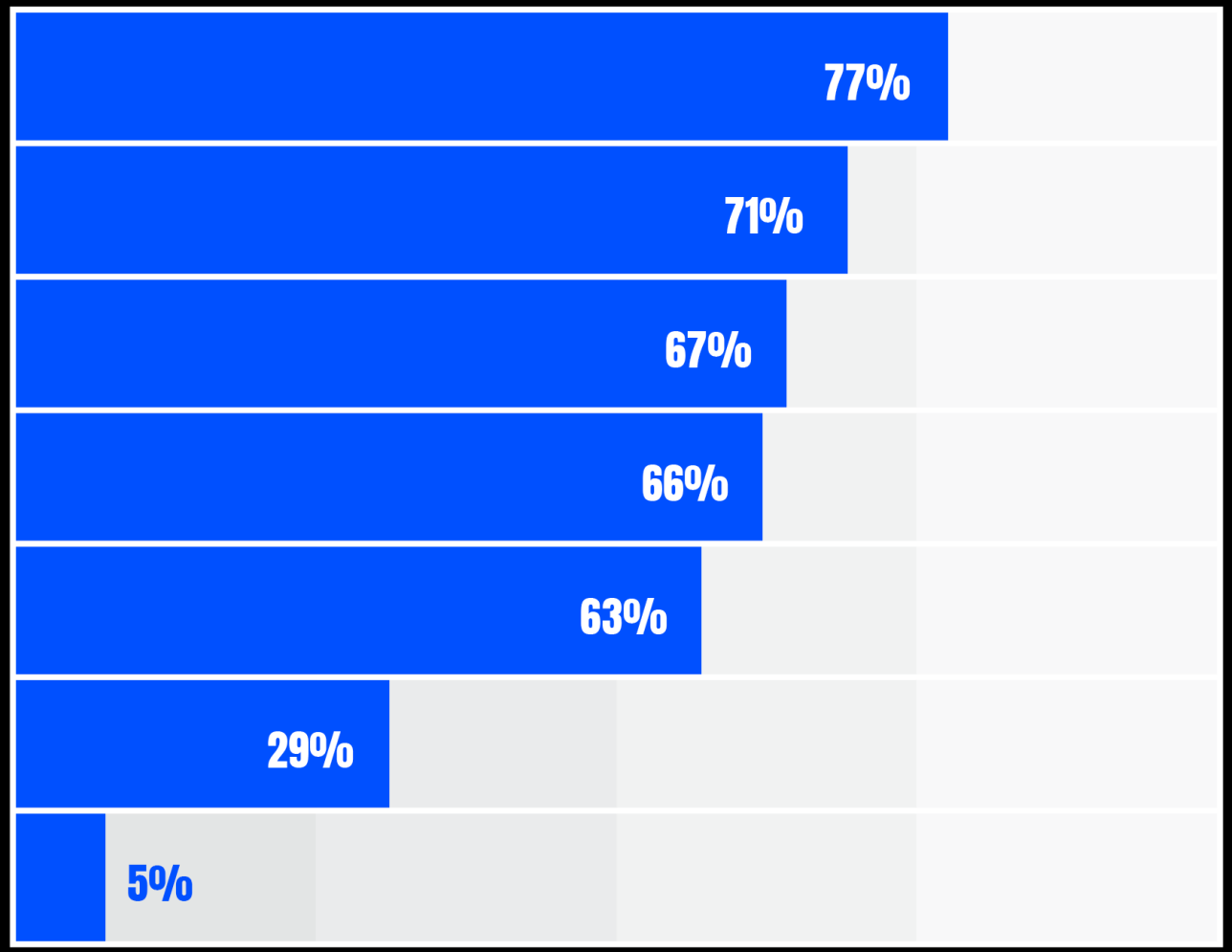
In the next two to five years, how likely is your organization to consider merging or consolidating with another healthcare organization?



Which model are you most interested in or considering?

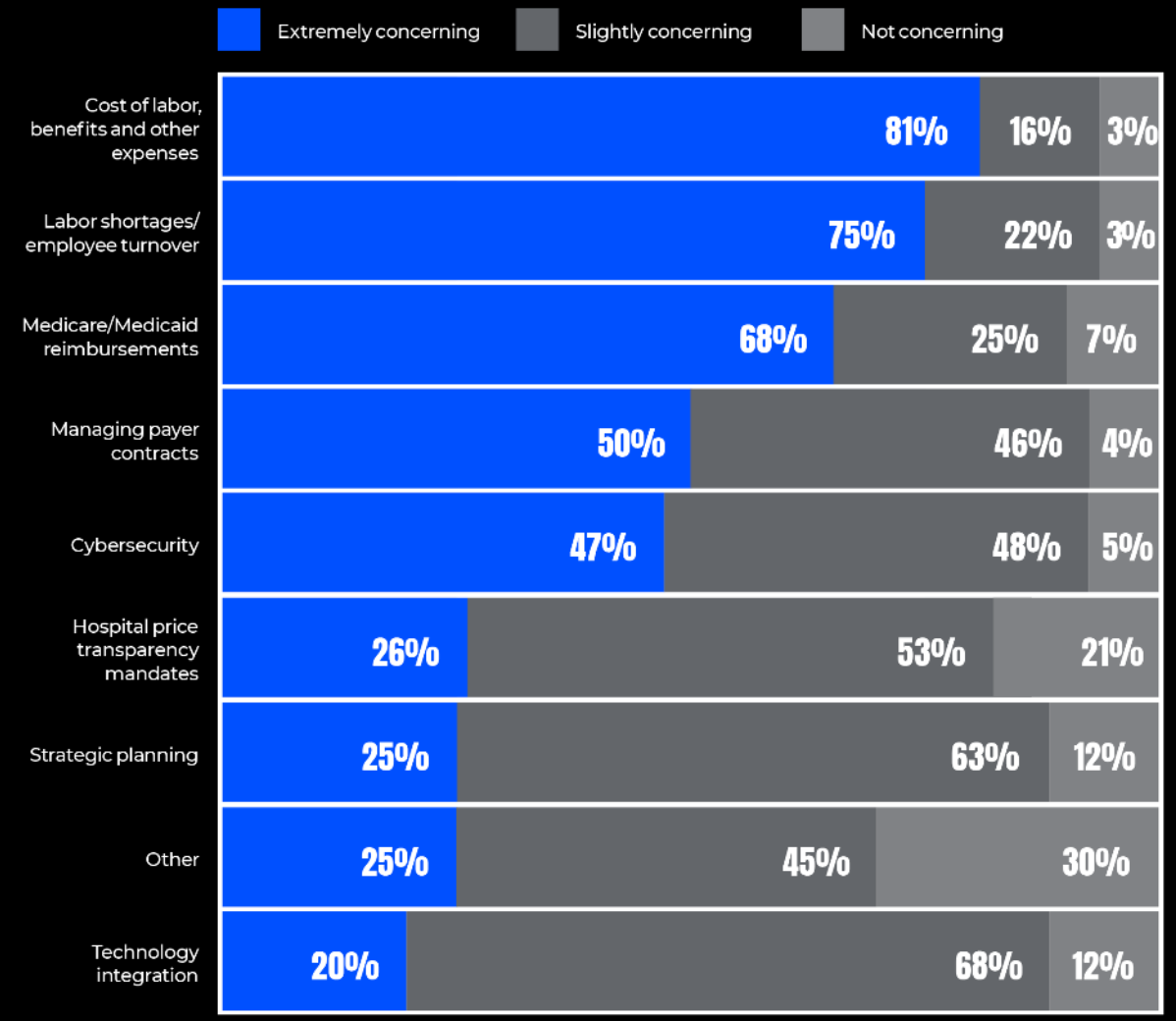


Which of the following tools have you developed/implemented to improve the consumer/patient experience?



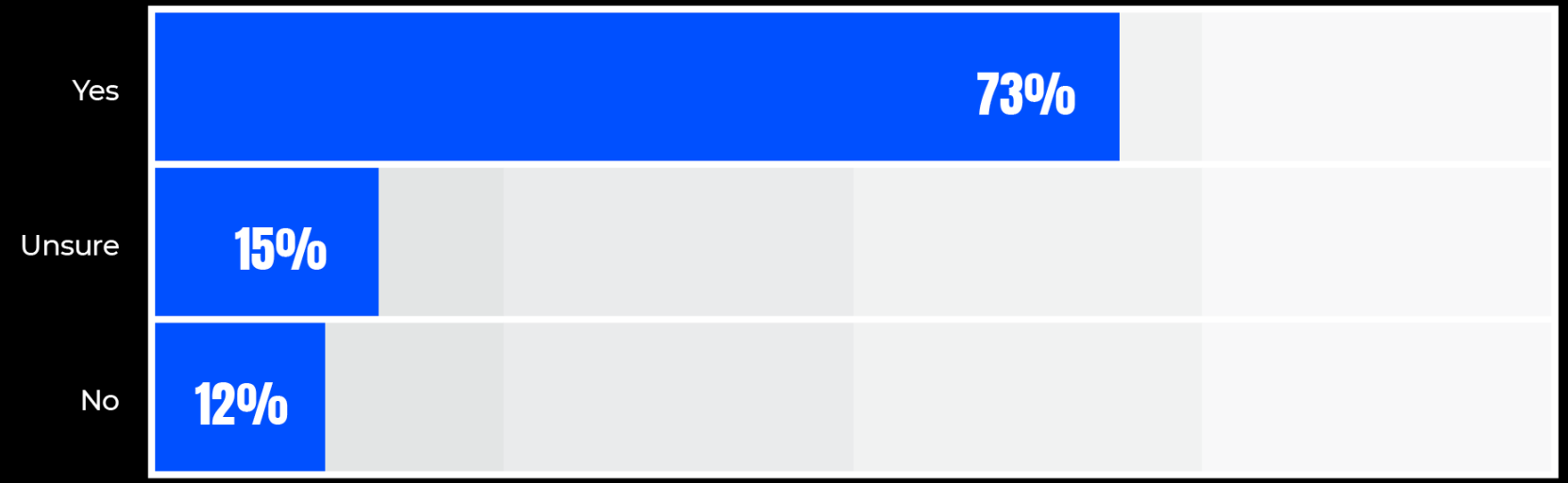
(Respondents were allowed to choose multiple responses.)

Please rate your level of concern for each of the following using a scale of 1–7 with 1 being "not concerning at all" and 7 being "extremely concerning."

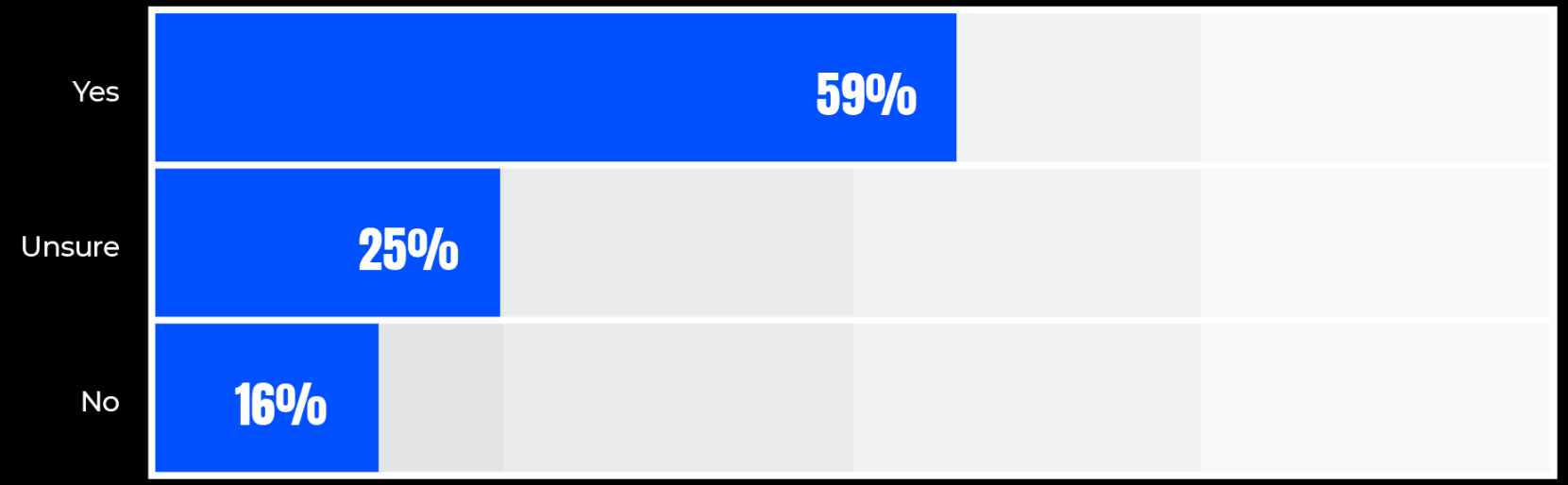


(Other responses included, infrastructure, provider issues and finances.)

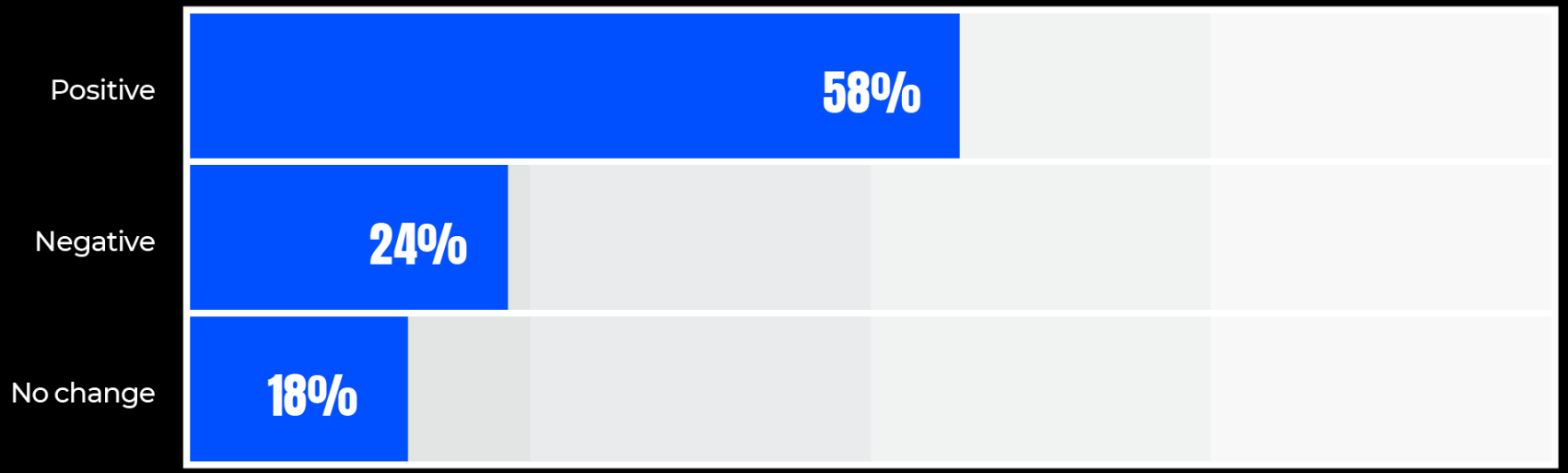
In the next two to five years, does your organization have plans to expand/invest in building new facilities or renovations?



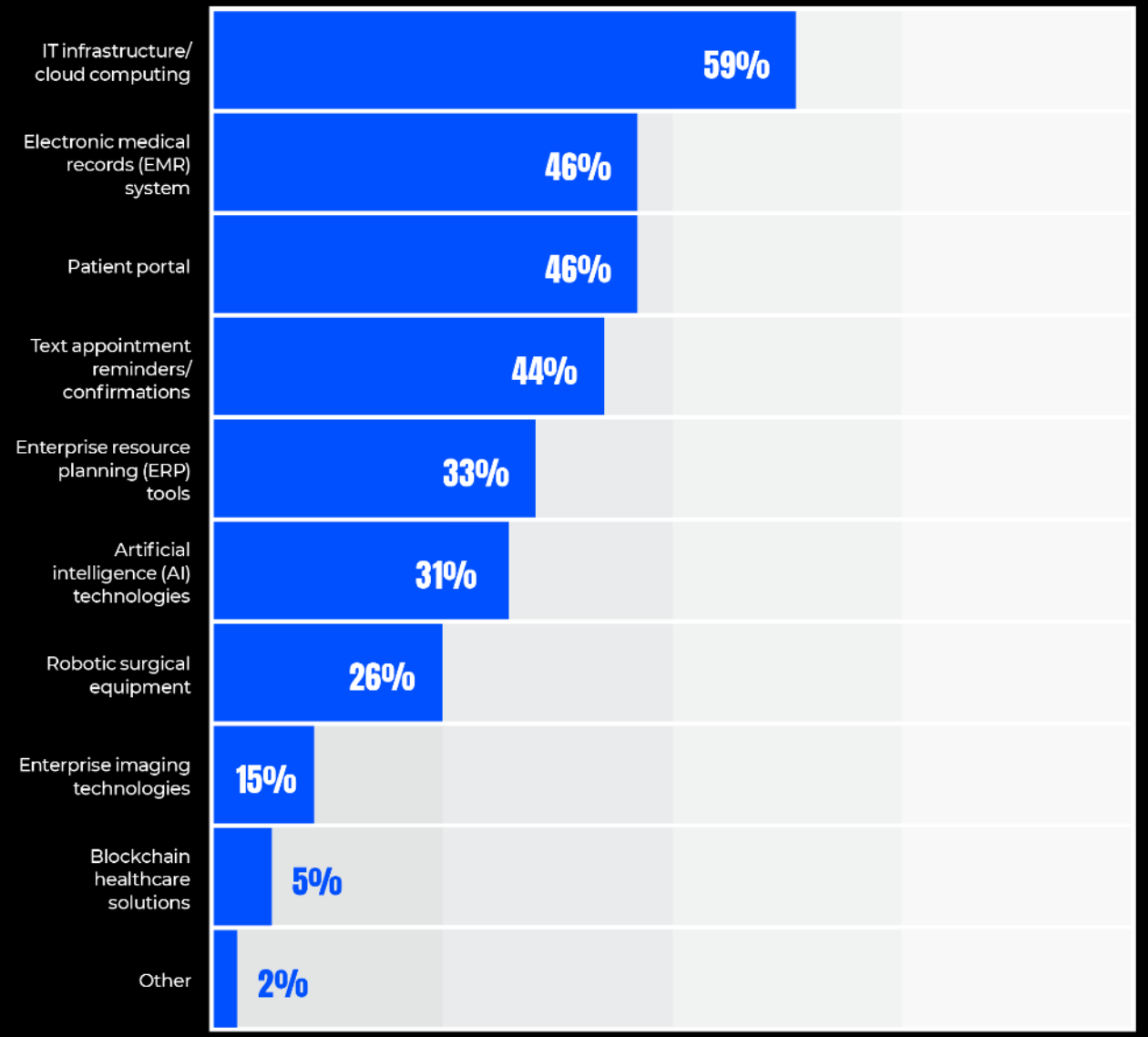
In the next two to five years, does your organization have plans to expand/invest in new technology platforms?



In terms of net revenue, which best describes the growth in your forecasted revenues over the next three years?



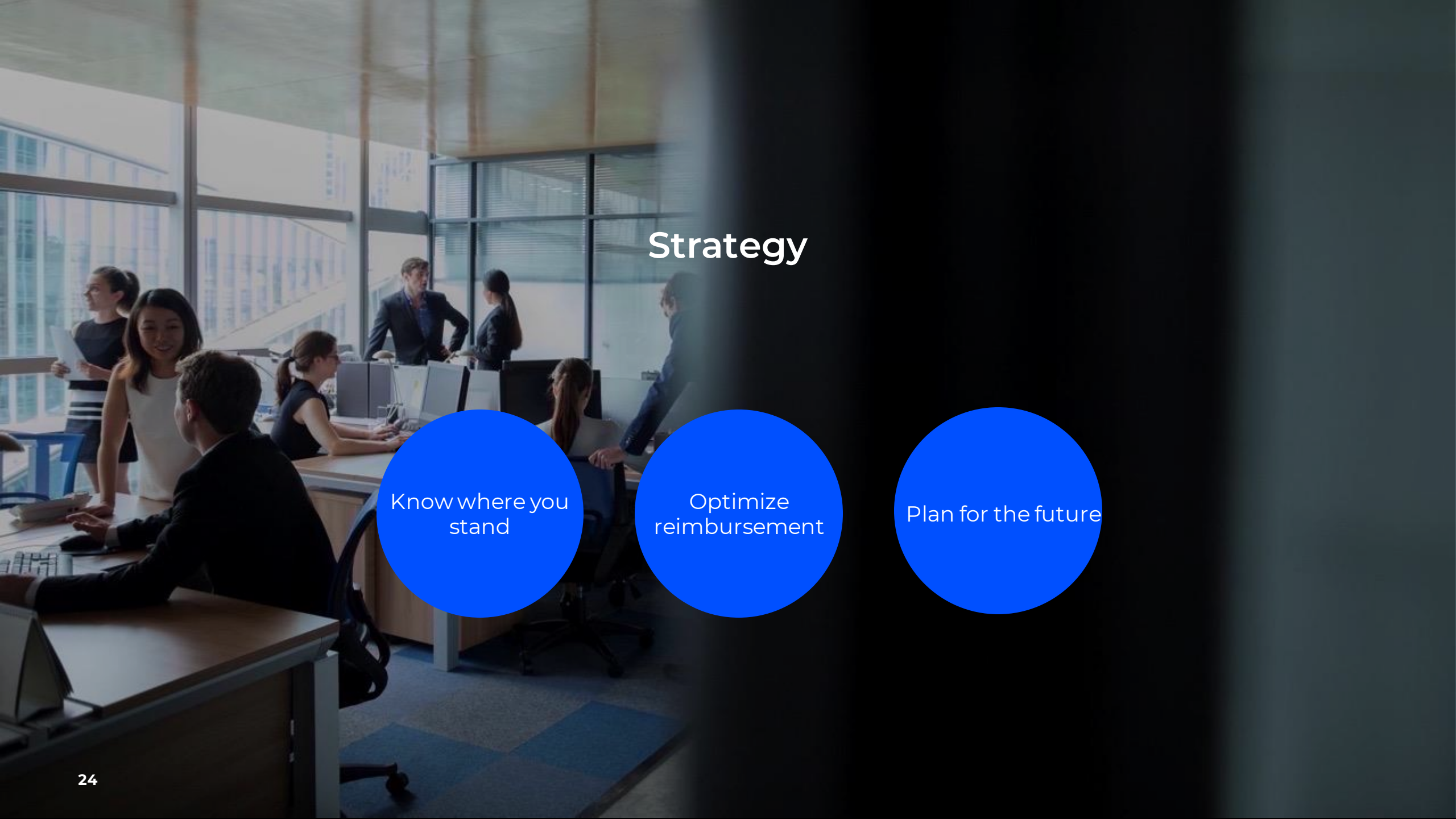
What technology systems do you plan to expand or purchase?



(Respondents were allowed to choose multiple responses.)

02

Strategic responses



Strategy

Know where you stand

Optimize reimbursement

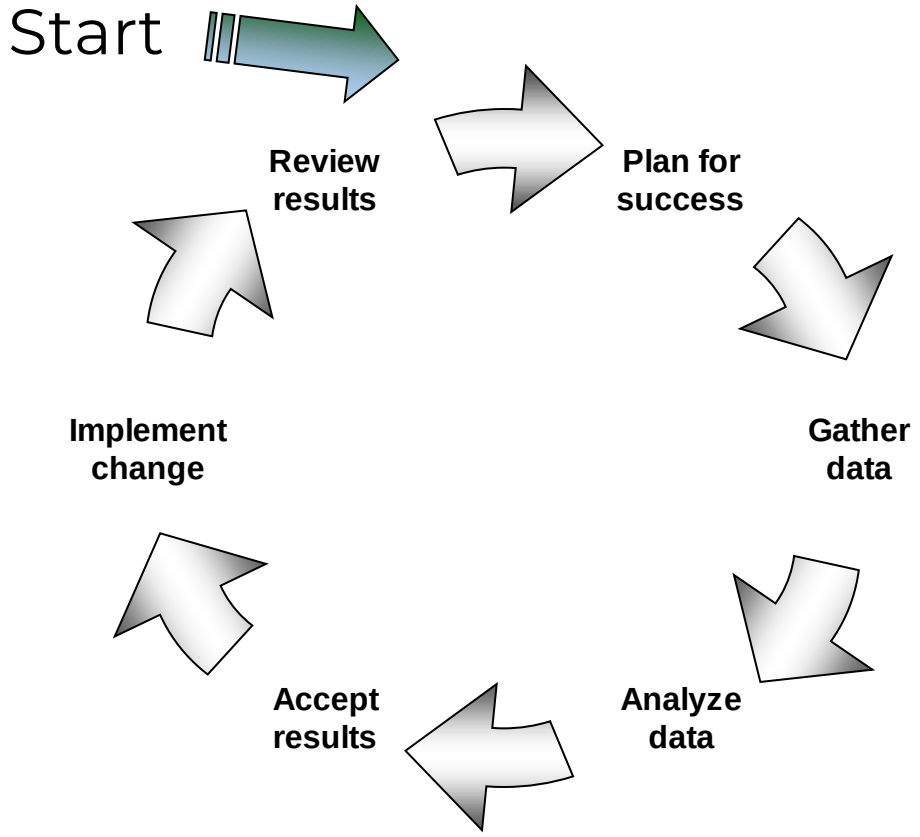
Plan for the future

“Benchmarking is the continuous process of measuring products, services, and practices against the toughest competitors or those companies recognized as industry leaders.”

-D.T. Kearns, Xerox Corporation

Principles of benchmarking

Key approach to benchmarking initiatives



Benchmarking helps us to drive the definition of:

- Targets - When have we achieved our goals?
- Alarms - When do we need to alert the organization to take action?

Wipfli LLP Median Financial Indicators Report

- Summary of key financial Indicators at a glance
- Included update for Western & Wipfli Top 100 for 2021 data (recently released)
- Note observations of the 2021 data

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Profitability Metrics	2021 Optum (2021)	2020 Optum (2020)	2020 Flex Team	Wipfli (2020) Western	Wipfli (2021) Western	Wipfli (2020) Top 100	Wipfli (2021) Top 100
EBITDA Margin	15.14%	7.54%	8.45%	6.75%	12.88%	9.38%	15.38%
Operating Margin	13.27%	4.85%	3.62%	5.96%	14.27%	7.50%	16.75%
Total Margin	15.52%	6.06%	5.41%	6.77%	19.40%	8.87%	20.66%
Liquidity Metrics							
Current Ratio	2.82	2.04	1.87	2.05	2.89	2.11	3.20
Days Cash on Hand	186.97	202.67	192.28	158.15	136.29	193.30	217.90
Day Revenue in Accounts Receivable - Net	61.6	60.12	47.25	48.27	53.49	46.35	46.34
Capital Metrics							
LTD to Capital	21%	13%	13%	14%	4%	8%	10%
Net Assets / Total Assets (Equity Financing)	61%	49%	49%	50%	59%	58%	61%
Debt Service Coverage	NR	NR	4.16	5.44	13.38	3.95	8.73
Average age of Plant	12.69	13.39	NR	13.03	12.57	13.59	12.92

Wipfli LLP Median Financial Indicators Report (based on 2020)

- Western CAHs included are AK, HI, WA, ID, OR, UT, NV, NM, AZ, & CA
- 295 CAHs included in the data
- Median Medicare days = 396, Medicaid days = 55, and total days = 790
- Avg. LOS = 2.88 days
- Acute Medicare cost per day = $3,959
- Total Medicare cost percent of the total allowable cost = 32%

WIPFLI

Profitability Metrics	Nevada (13)	New Mexico (10)	Arizona (15)	California (36)	Western (295)	Top 100 CAH 25th Percentile	Top 100 CAH Median	Top 100 CAH 75th Percentile
EBITDA Margin	4.18%	4.43%	4.81%	6.24%	6.75%	5.98%	9.38%	12.82%
Operating Margin	3.01%	3.95%	5.72%	8.18%	5.96%	4.21%	7.50%	13.77%
Total Margin	3.09%	5.14%	8.09%	11.42%	6.77%	4.84%	8.87%	16.67%
Liquidity Metrics								
Current Ratio	2.8	1.79	2.66	1.99	2.05	1.59	2.11	3.23
Days Cash on Hand	145.04	117.86	84.46	126.47	158.15	81.23	193.3	288.95
Day Revenue in Accounts Receivable - Net	55.08	33.24	51.68	40.76	48.27	39.25	46.35	55.54
Capital Metrics								
LTD to Capital	0	0.05	0.16	0.22	0.14	0	0.08	0.35
Net Assets / Total Assets	0.64	0.57	0.59	0.49	0.5	0.37	0.58	0.74
Debt Service Coverage	4.03	10.69	6.9	5.77	5.44	2.06	3.95	11.86
Average age of Plant	12.17	10.56	12.97	14.62	13.03	9.9	13.59	19.01
Staffing Metrics								
FTEs	151.7	175.97	216.54	210.97	170.43	93.87	151	233.13
Salary per FTE	67,550	70,393	64,091	72,373	70,429	54,010	62,558	72,438
Salary/Total Expense	0.43	0.41	0.42	0.41	0.44	0.38	0.43	0.47
Salary to Net Patient Service Revenue	0.51	0.44	0.44	0.42	0.47	0.39	0.46	0.53

Wipfli LLP Median Financial Indicators Report

- Operational data based 2021 reports

Patient Stats	Western	Midwest	Southern	Top 100 CAH 25th Percentile	Top 100 CAH Median	Top 100 CAH 75th Percentile
Acute Medicare Days (Inc ICU)	320	411	370	290	521	899
Acute Medicaid Days (Inc ICU)	52	12	18	2	28	82
Acute Total Days (Inc ICU)	816	745	747	462	951	1,594
Acute Medicare Utilization	50%	58%	48%	52%	59%	72%
Acute Medicaid Utilization	7%	2%	3%	0%	2%	6%
Swing Bed Medicare Days	303	440	690	319	508	643
Swing Bed Total Days	623	602	1117	523	686	995
Swing Bed Medicare Utilization	65%	74%	69%	62%	75%	85%
Discharges - Medicare	95	120	105	92	159	242
Discharges - Total	246	236	227	149	300	490
Average Length of Stay - Days	3.18	3.18	3.41	2.76	3.11	3.3
Average Length of Stay - Hours	76.42	76.21	81.77	66.19	74.61	79.09
Cost Report Statistics						
Acute Medicare Routine Costs per Day	2,615	2,266	1,520	1,832	2,325	2,975
Acute Medicare Ancillary Costs Per Day	1,079	992	877	772	1036	1,294
Acute Medicare Cost Per Day	3,994	3,410	2,527	2,713	3,479	4,319
Swing Bed Medicare Routine Costs per Day	2,498	2,234	1,498	1,825	2,263	2,959
Swing Bed Medicare Ancillary Costs per Day	446	464	472	372	428	515
Swing Bed Medicare Cost Per Day	3,012	2,732	2,048	2,298	2,688	3,378
Part B Medicare CCR	54%	44%	39%	43%	48%	56%
Acute Medicare Ancillary Charges Per Day	2,100	2,495	2,294	1,719	2,325	2,785
Swing Bed Medicare Ancillary Charges per Day	831	1,058	1124	701	860	1,089
Inpatient Medicare Bad Debt Claimed per Day	11.48	11.64	34.59	0	9.98	25.05
Outpatient Medicare Bad Debt Claimed / Medicare OP Charges	0.50%	0.41%	1.69%	0.11%	0.31%	0.96%
Swing Bed Medicare Bad Debt Claimed per Day	0	0	0	0	0	0
Cost Report Metrics						
Acute Medicare Cost Percent of Total Allowable Cost	6%	6%	6%	6%	8%	11%
Swing Bed Medicare Cost Percent of Total Allowable Cost	4%	6%	10%	3%	6%	10%
Outpatient Medicare Cost Percent of Total Allowable Cost	15%	20%	13%	19%	24%	28%
Total Medicare Cost Percent of Total Allowable Cost	31%	33%	31%	32%	40%	45%

Wipfli LLP Median Financial Indicators Report

- Financial Indicator Data based 2021 reports

Profitability Metrics	Western	Midwest	Southern	Top 100 CAH 25th Percentile	Top 100 CAH Median	Top 100 CAH 75th Percentile
EBITDA Margin	12.88%	12.88%	7.68%	11.35%	15.38%	19.21%
Operating Margin	14.27%	15.03%	11.75%	12.79%	16.75%	21.12%
Total Margin	19.40%	18.40%	14.04%	14.80%	20.66%	26.78%
Liquidity Metrics						
Current Ratio	2.89	2.25	1.71	2.21	3.2	4.71
Days Cash on Hand	136.29	149.59	91.25	121.59	217.9	320.42
Day Revenue in Accounts Receivable - Net	53.49	45.42	46.12	39.9	46.34	54.32
Capital Metrics						
LTD to Capital	0.04	0.1	0.01	0	0.1	0.3
Net Assets / Total Assets	0.59	0.53	0.54	0.47	0.61	0.78
Debt Service Coverage	13.38	7.82	7.22	4.92	8.73	18.01
Average age of Plant	12.57	12.85	13.2	10.63	12.92	16.37
Staffing Metrics						
FTEs	154.78	156.15	127.16	94.2	150.99	230.93
Salary per FTE	70,659	66,676	59,283	56,788	65,469	74,910
Salary/Total Expense	0.43	0.41	0.43	0.37	0.42	0.47
Salary to Net Patient Service Revenue	0.45	0.42	0.47	0.37	0.44	0.51
Payor Mix						
Outpatient Medicare	20%	28%	17%	25%	29%	33%

Wipfli/NARHC Rural Health Clinic Benchmark Report

Category/Indicator	12/31/2018 RHC Values	12/31/2018 Mean WA	12/31/2018 Mean Western	12/31/2018 Mean Nation	12/31/2019 RHC Values	12/31/2019 Mean WA	12/31/2019 Mean Western	12/31/2019 Mean Nation	12/31/2020 RHC Values	12/31/2020 Mean WA	12/31/2020 Mean Western	12/31/2020 Mean Nation
Number of Facilities	1	77	461	2,361	1	80	460	2,468	1	75	481	2,610
Encounters per FTE:												
Physicians	4,062	3,707	4,020	3,976	4,252	3,454	3,821	3,901	3,475	2,916	3,367	3,472
Physician Assistants	2,335	3,205	3,483	3,188	1,792	3,398	3,539	3,147	1,243	2,578	2,936	2,747
Nurse Practitioners	0	2,909	3,106	2,865	2,509	2,513	3,032	2,876	1,914	2,338	2,698	2,604
Clinical Psychologist/Social Worker	1,174	1,500	1,630	1,498	1,058	1,300	1,549	1,499	734	1,062	1,502	1,276
Total Encounters	15,719	1,103,592	5,639,341	25,258,132	16,269	1,181,644	5,953,776	27,179,505	13,014	712,184	5,034,987	25,365,033
Midlevel Staffing Ratio	27%	47%	54%	55%	29%	49%	54%	56%	31%	50%	55%	57%
Midlevel Visit Ratio	18%	42%	45%	46%	16%	44%	46%	48%	15%	46%	47%	48%
Cost per Encounter:												
Physician	128.93	121.98	117.16	100.70	135.87	129.90	126.06	106.66	178.42	162.13	144.13	118.82
Physician Assistant	136.17	75.65	56.55	50.35	194.18	76.08	52.40	52.27	299.11	104.32	66.97	61.74
Nurse Practitioners	0.00	37.97	60.55	49.08	83.84	41.26	62.94	50.39	268.49	69.45	68.80	57.03
Clinical Psychologist/Social Worker	112.26	25.65	41.37	41.89	116.10	37.72	42.22	35.42	191.96	107.96	70.30	45.88
Total Health Care Staff Cost	44.98	34.89	36.90	28.47	49.01	39.84	38.10	29.45	86.01	48.38	44.86	33.93
Cost per FTE:												
Physician	523,720	431,088	400,033	353,962	577,746	424,386	440,036	379,073	620,081	434,770	431,047	374,521
Physician Assistant	318,026	242,482	196,983	160,513	347,979	258,539	185,465	164,467	371,683	268,927	196,629	169,598
Nurse Practitioner	0	110,447	188,086	140,591	210,322	103,708	190,874	144,893	513,964	162,370	185,660	148,515
Clinical Psychologist/Social Worker	131,810	38,486	67,460	62,760	122,832	49,033	65,410	53,085	140,899	114,698	105,574	58,528
Total Healthcare Staff Costs per Provider FTE	173,304	123,603	149,905	101,996	187,613	132,508	147,659	103,654	255,550	133,338	152,359	106,538
Clinic Cost per Encounter:												
Total Health Care Staff	174.81	123.97	108.43	96.18	188.17	132.20	117.69	101.58	281.10	168.02	134.14	114.66
Total Direct Costs of Medical Services	181.46	137.70	140.47	119.80	191.57	148.36	146.53	123.78	288.69	190.56	169.20	138.80
Clinic Overhead	15.52	33.38	24.18	24.69	15.94	32.60	26.26	26.60	22.76	37.62	30.74	30.63
Parent Provider Overhead Allocated	90.61	74.78	96.79	81.06	92.45	81.13	99.30	83.63	136.31	137.63	122.94	96.63
Allowable Overhead (Clinic and Parent)	106.13	108.05	119.74	104.83	108.39	113.24	123.31	109.18	156.92	170.93	147.82	124.39
Allowable Overhead Ratio (Clinic and Parent)	100%	100%	99%	99%	100%	100%	98%	99%	99%	98%	96%	98%
Total Allowable Cost per Actual Encounter	287.59	245.75	259.58	223.78	299.96	260.81	269.68	232.15	445.61	359.85	316.79	262.48
Total Allowable Cost per Adjusted Encounter	284.83	231.68	248.80	213.77	298.94	241.95	254.33	221.30	444.99	332.74	300.67	252.83
Cost of Vaccines and Administration per Adjusted Encounter (Reimbursed Separately)	(8.07)	(4.27)	(5.66)	(6.21)	(6.48)	(4.11)	(5.66)	(6.77)	(10.87)	(8.29)	(6.99)	(8.21)
Rate per Adjusted Encounter	276.76	227.41	243.14	207.56	292.46	237.84	248.67	214.53	434.12	324.45	293.68	244.62
Total Medicare Encounters	5,718	312,883	1,396,321	6,362,621	5,552	335,391	1,499,683	6,730,574	4,598	199,901	1,233,603	5,907,972
Medicare Percent of Visits	36%	28%	25%	25%	34%	28%	25%	25%	35%	28%	25%	23%
Injection Cost:												
Cost per Pneumococcal Injection	409.54	300.86	298.73	280.61	260.83	289.85	299.05	295.95	160.67	298.58	310.18	329.20
Cost per Influenza Injection	48.14	81.67	92.14	79.87	57.59	80.19	91.03	85.69	62.03	87.03	97.72	140.66

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NARHC
NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS

“Put the squeeze on Medicare reimbursement.”

–Michael R. Bell

Reimbursement optimization

Rural Health Clinics

Despite the changes in Medicare payments for RHCs, newly certified RHCs are still proving to be a viable option for organizations. In addition, there are some options to consider for both grandfathered and newly-certified RHCs.

Rural Emergency Hospital

Rural Emergency Hospitals (REH) are a new provider type established by the Consolidated Appropriations Act, 2021 to address the concern over closures of rural hospitals, effective 1/1/2023.

Commercial Payor Contracting

Often, one of the most overlooked areas for increased net revenue opportunities relates to commercial contracts. Understand the major payors, contract terms, and if it's time to ask for more.

Rural Emergency Hospitals

Rural Emergency Hospitals overview

- To be eligible for REH status, hospitals must have 50 or fewer beds and either be in a rural area or have an active rural reclassification
- REHs are required to provide 24-hour emergency services, laboratory services, diagnostic radiological services, pharmacy or drug store area, and discharge planning by qualified professional
- REHs can also provide other outpatient services such as behavior health, radiology, and outpatient rehab. An REH may also establish a separate, distinct part unit licensed as a Skilled Nursing Facility
- REHs must meet Critical Access Hospitals CoPs for Emergency Services
- Cannot have per-patient averages exceed 24 hours (individual patient stays can exceed 24 hours)
- Can provide observation care and additional medical outpatient services
- All covered outpatient services provided by REHs will receive an additional 5% increase in payment of the standard OPPS rate that would be paid (none of this additional 5% would be charged to beneficiary coinsurance)
- In addition to the 5% increase, REHs will also receive an additional monthly facility payment from Medicare. This facility payment will increase annually by the market basket percentage which is established by CMS. The current established facility payment for 2023 will be $272,866 per month
- A hospital that converted to an REH is able to convert back to their previous provider type as long as the conditions of participation are met.

Rural Emergency Hospitals drawbacks

- REHs are not considered an eligible provider for 340B drug pricing
- REH-designated hospitals can no longer provide inpatient or swing-bed care and must have a transfer agreement with at least one Medicare-certified hospital designated as a Level I or Level II trauma center. (REHs can provide SNF services; however, must gain licensure and create a distinct part unit for SNF services which may have previously been done under a hospital's swing bed license.)
- With this being a brand-new provider type there are a lot of unknowns and there could be several changes to this provider type in the future periods
- Not all states have established REH rules yet regarding REH's
- Hospitals that are currently operating with an inpatient unit would have to make determinations on what to do with staff that would no longer be needed (terminations or transfers to other locations)
- Community perspective of no longer offering inpatient services and handling of employees who would no longer be needed
- REHs that would make the determination to transition back to old hospital type could have challenges filling positions

Rural Emergency Hospitals Medicare payment overview

Type of service	PPS Hospital	CAH	REH
Inpatient	DRG	101% of Allowable Cost	N/A
Outpatient Procedures (surgery, radiology, etc.)	APC Sole Community Hospital is Reimburse at APC +7.1%	101% of Allowable Cost (except for screening mammography and orthotic DME items)	APC +5%
Lab	Fee Schedule	101% of Allowable Cost (except for reference lab)	Fee Schedule
Therapies	Fee Schedule	101% of Allowable Cost	Fee Schedule
Swing Bed	RUG	101% of Allowable Cost	N/A

Rural Emergency Hospitals Medicare payment overview

Type of service	PPS Hospital	CAH	REH
O/P Clinics (facility component)	APC Sole Community Hospital is Reimburse at APC +7.1%	101% of allowable cost	APC +5%
O/P Clinics (professional component)	Fee schedule (reduced for site of service)	Fee schedule plus 15% for CAHs Electing Method II Billing (reduced for site of service)	Fee schedule
CRNA services	Fee schedule (unless elect cost if less than 800 procedures/year)	Fee schedule (unless elect cost if less than 800 procedures/year and 1 FTE/year)	Fee schedule
Other professional services	Fee schedule – Except for professional services in a rural health clinic, then generally based on allowable cost	Fee schedule plus 15% for CAHs Electing Method II Billing (except for professional services in a rural health clinic setting then generally based on allowable cost)	Fee schedule – Except for professional services in a rural health clinic, then generally based on allowable cost
Outlier payments	Cost – generally insignificant for rural providers	N/A	Cost – generally insignificant for rural providers

Example of high-level analysis REH conversion

Description	REH Conversion Financial Impacts
Additional REH Add-On Payment	$ 3,270,000
5% Addition to OPPS Payments	80,000
Loss of 340B Status	(70,000)
Loss of SCH Status	(130,000)
Loss of Inpatient Revenue	(1,500,000)
Decrease of Expense Due to Closure of IP Unit (Includes Overhead, IP Unit, and Ancillary)	1,240,000
CAH Increased IP, Swing & OP Reimbursement	N/A
Estimated Medicare Advantage Plan Impact	N/A
Estimated CAH Method II Impact	N/A
Estimated 340B Impact	N/A
Estimated Illinois Medicaid CAH Add-On and Direct Payment Changes	N/A
Total Additional Income	$ 2,890,000

Rural Health Clinics

Strategy: Mobile RHCs

- Mobile RHCs for Medicare use an existing Medicare RHC rate:
  - So, in theory, if a hospital developed a mobile RHC, it may not be subject to the new Medicare RHC caps
- No new certification – The RHC is basically an extension of the existing RHC
  - RHC conditions of participation do not have to be met in the mobile unit as long as the clinic as a whole (permanent and mobile unit) meet the requirements
  - Must provide services in a rural area and that location must have a current shortage designation
  - Services in the location must have a consistent schedule

Strategy: Mental health services

- Beginning in 2022, Medicare pays mental health telehealth services as a “distant site” paying at the AIR
  - Patients must have been seen within the last 12 months (there are exceptions to the rule and this have been delayed until 1/1/2025)
  - This change in reimbursement allows RHCs to contract with remote behavioral health providers to offer telehealth visits and receive their AIR payment
- Beginning in 2024, Mental Health Counselors (MHC) and Licensed Marriage and Family Therapists (LMFT) are recognized by Medicare as RHC providers

Strategy: HOPD to RHC or stay as existing HOPD?

- As the Medicare cap continues to grow, it may be advantageous to convert existing hospital outpatient department (HOPD) clinics to RHCs
  - Why? Medicare RHC rates may eventually be higher than the Medicare fee for service rates
  - HOPD status could be advantageous depending on the service mix; specialty services are often reimbursed higher by Medicare in a HOPD
- Does the state recognize HOPD status?

Strategy: Review the Medicaid RHC rate

- Make sure your RHC Medicaid rates are maximized
- Has your clinic considered a change in scope of services request if allowed by your state?

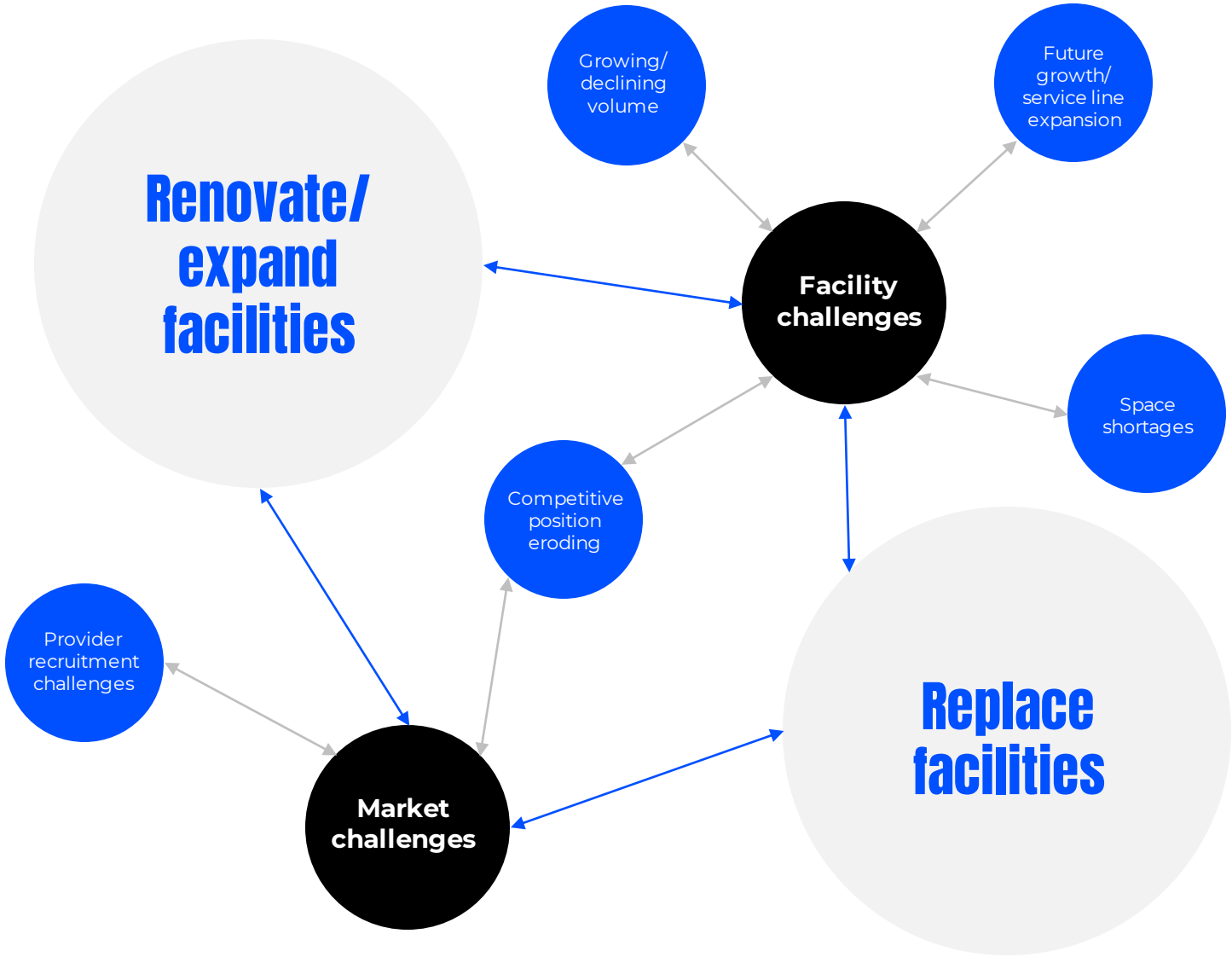
Note: A loss in Medicare RHC reimbursement may be offset by a gain in Medicaid RHC reimbursement. RHC status may still make sense depending on your state's RHC reimbursement rates and your clinic's payer mix.

“If you fail to plan, you are planning to fail.”

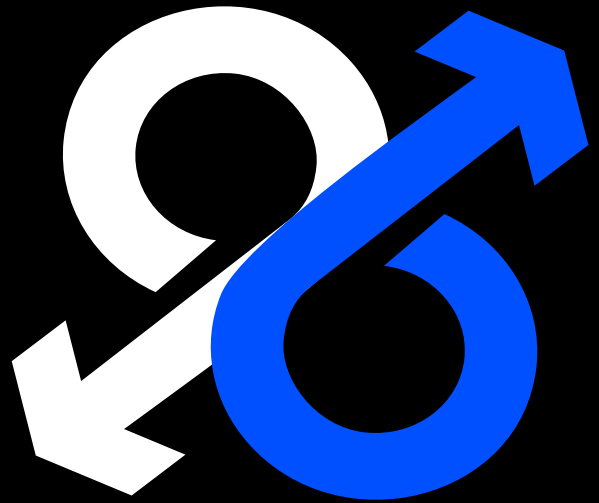
– *Benjamin Franklin*

Which facility development strategy is best for you depends on multiple factors

The existing state of your campus and facilities, future growth/facility needs, and affordability play a direct role on what facility options are feasible



Transformative Leadership Linkage



YOUR PEOPLE STRATEGY MUST CONNECT TO YOUR BUSINESS STRATEGY

WIPFLI

The process

01

Business plan

Cascades throughout the organization.

02

People strategy

Broad strategies identified for people to implement the business strategy.

03

Standards

Leader standards or philosophy created summarizing what leaders need to know.

04

Development plan

Development plan created from standards and from gaps identified with current leaders for existing and future roles.

05

Execution

Programs, coaching, and other traction items put into play for all leaders.

06

Measure throughout

03

Closing comments and Q&A

Q & A

Things to think about

- Benchmarking: How do you stack up?
- Reimbursement strategies: Where to focus?
- Planning for the future:
  - Strategic planning?
  - Capital planning ?
  - People planning ?

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